Instructions for Completing Critical Incident Reports

I. Overview

The Department of Health and Family Services is required by the Centers of Medicare and Medicaid (CMS) to insure the health, safety and welfare of Home and Community-based waiver participants. The Department shares this responsibility with County agencies in the State-County Contract by requiring County compliance with the Medicaid Waivers Manual. Chapter IX of this Manual requires each County agency administering any of the waivers to have an adequate system to ensure waiver participants are adequately protected form physical, verbal and sexual abuse. Maltreatment, neglect, financial exploitation and violations of their rights under law. Chapter 9 also requires counties to have an effective response system when Incidents of this kind arise. The Manual also specifies Critical Incident Reporting requirements for counties. The Manual requires County agency staff to report Critical Incidents as defined here. Please refer to the Medicaid Waiver Manual, Chapter IX: Assuring Health, Safety and Welfare, for detailed information.

II. Timelines

The County must report all Critical Incidents to the assigned CIS within 30 days of the Incident. **If a CI has the potential of becoming a high profile situation, the County is asked to immediately contact the assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any assistance that may be needed.**

Completion of the BDDS Critical Incident Report does not meet any other requirements for reporting events, deaths or misconduct to other state or County agencies. Please visit the Department web site for additional information regarding reporting requirements at www.dhfs.state.wi.us.

III. Procedures:

The following is a recommended sequence of procedures county staff and the service providers involved may wish to follow in responding to reportable critical incidents.

1. Immediately upon learning of an allegation of a critical incident, the service provider should determine if the allegation is credible. If there is reasonable cause to believe that the report may be accurate, the service provider should proceed with the next steps listed here.

2. The service provider's first responsibility is to take necessary actions to protect waiver participants from the potential of harm. In doing this, they should preserve possible evidence for an investigation if one is to be conducted.

3. The provider must notify the case manager/service/support coordinator or designated county staff of the allegation and results of any action taken. Agencies are expected to notify local law enforcement authorities in any situation where there is a potential violation of criminal law.

4. The county case manager/ Service/support coordinator should notify the guardian is about the situation/ incident.

5. **If an incident has the potential of becoming a high profile situation, county agency staff are asked to immediately contact their assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any**

assistance that may be needed. Knowledge of such situations by department staff often helps alleviate concerns that may come from legislators or the media about the adequacy of responses that might arise if the department is not so informed.

6. The county staff or their agents/contractors who are involved should promptly determine if the critical incident occurred and if the person's with on-site responsibility have taken the necessary steps to ensure participant health, safety and welfare as required by the waiver. County staff should also determine if the service provider's procedures and responses were adequate. The county must take action to ensure that any remedial action needed is taken.

7. If county staff determine that the situation or event occurred, they should next determine if a longer term, a substantive response or change is warranted. County staff should take all actions necessary to make the changes needed including substitution of provider, termination of contracts, etc. These may occur after the initial CIR but shall be reported in updates to the initial CIR.

8. The CIR is intended to summarize the details of the incident, the county's review and participant outcomes. Each such incident should also be viewed as a test of the adequacy of the county's response system. County staff shall send the completed Critical incident form (DSL 2558) to their assigned CIS. Reports shall be within 30 days of the incident unless other arrangements have been made with the CIS. For active situations, Counties are encouraged to submit the report earlier.

9. If a county is unable to gain access to certain findings or records within the 30 day time frame due to concurrent investigations or other extenuating circumstances beyond their control, the county should send in all available information with a notation that the initial report is not complete. County staff should indicate when the rest of the report is anticipated if that is known or can be predicted.

10. County agencies are responsible for "closing" all critical incident reports. Closing here means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the report. Follow up visits or future targeted reviews are usually not expected to be part of the report unless they occur within a short time frame.

11. The DSL/BDDS staff will review all CIRs. This review is intended to determine:
    - if participant's health, safety and welfare are now adequately protected;
    - that the response to the situation and event was reasonable and appropriate;
    - that the county's procedures and system for responding to such incidents were adequate;
    - that the participant's service plan is adequate;
    - that where relevant, steps to prevent similar incidents were taken;
    - that all service providers or staff involved in the incident appear to be adequately trained or that additional training needed is to be provided pursuant to the report;

12. County staff should take special note that all other required reporting procedures such as Child abuse reporting and the timelines of other required reports remain in force and are not replaced or superseded by this process.

III. Definition of Critical Incidents and Key Terms

1. **Critical Incidents** are events or situations that pose an immediate and/or serious risk to the physical or mental health, safety, or well being of a waiver participant. A Critical Incident may also involve the misappropriation of a waiver participant's property or a violation of the person's rights. Waiver participants covered by this include people with a developmental disability or acquired brain injury who participate in one of the Medicaid Waivers administered by the Bureau of Developmental Disabilities Services (BDDS). Critical Incidents that are alleged to have occurred as well as the results of internal investigations are to be reported. If the reported Critical Incident is determined to be unfounded, the report should still be submitted.

2. **Abuse** means any of the following:
   a. An act, omission or course of conduct by another that is inflicted intentionally or recklessly and that does at least one of the following:
      (1) Results in bodily harm or great bodily harm to the individual.
      (2) Intimidates, humiliates, threatens, frightens or otherwise harasses the individual.
   b. The forcible administration of medication with the knowledge that no lawful authority exists.

   Examples of abuse include:
   - mental/emotional abuse - threats of harm, name calling, blaming, ignoring, threatening to withhold personal property or denying client rights or use of tonal inflection that intimidates, humiliates, threatens, frightens or otherwise harasses the individual
   - physical abuse - hitting, slapping, pinching, or grabbing a person that causes pain or injury
   - physical abuse - use of a mechanical or chemical restraint, isolation or seclusion without prior Departmental approval
   - physical abuse - restricting the use of a mobility device or intentionally failing to provide necessary assistance for activities of daily living
   - sexual abuse - inappropriate physical contact, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature
3. **Community setting** means a public location that is not under an agency's control such as a park, roadway, shopping center, YMCA or other public accommodation.
4. **Death-accidental** means an unanticipated death that is the consequence of a specific negative and unintentional event such as a medical error, motor vehicle accident, airway obstruction by a foreign object or food or ingestion of a toxic substance. An accidental death is <u>not</u> abuse or neglect.
5. **Death-anticipated** means a death that was medically predicted to occur within six months if only routine and comfort interventions was provided. Anticipated deaths do not include the death of a person with a life-long disability that has been reasonably stable.
6. **Death-related to psychotropics** means death that was contributed to by the use or withholding of a psychotropic medication, or adverse reactions to a psychotropic medication.
7. **Death-related to restraints** means the person was either in restraints, seclusion, or isolation at the time of death or the death was directly related to the proper or improper use of restraints, seclusion, or isolation.
8. **Death-related to suicide** means the participant intentionally placed himself or herself in harm with a reasonable belief that it would result in their death.

9. **Death-unanticipated** means a death that was not predicted or anticipated within 6 months, or caused by an accident. An unanticipated death may be the result of abuse, neglect, an emergency medical condition, high-risk medical procedure, or sudden decline from of a pre-existing medical condition. Deaths due to ruptured bowel, cardiac arrest, pneumonia, sepsis, seizure, or stroke are examples of unanticipated deaths. If the death was related to abuse or neglect, this must be documented in the CIR.

10. **Hospitalization-emergency** means unscheduled medical treatment needed for the sudden and unexpected onset of a medical situation that, if immediate medical attention was not received, could result in death or serious injury to the person.
    Examples of emergency hospitalization include:
    - admission for heart attack, stroke, severe shortness of breath,
    - assessment following a significant trauma event
    - significant loss of blood
    - burns or frostbite over a large portion of the body

11. **Hospitalization-mental health/behavioral** means an emergency or pre-scheduled overnight admission for assessment or management of an unstable mental condition or high-risk behaviors that require management by a physician.
    Examples of mental health/behavioral hospitalization include:
    - emergency detention for mental health symptoms or behaviors
    - deterioration of behavior that requires inpatient assessment
    - admission to an inpatient psychiatric unit for urgent medication adjustment

12. **Isolation** means any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease.

13. **Law authority contact** means a participant is the subject of an investigation by law enforcement or the victim of an event that is reported to law enforcement.
    Examples of law authority contacts that <u>are</u> a critical incident include:
    - motor vehicle accidents or driver violations that pose a safety risk to a participant **and** the participant is a passenger in the vehicle at the time of the accident or violation **or** is struck by a moving vehicle
    - physical detention by law authorities of a participant for disruptive behaviors, possible or actual legal action or parole revocation
    - investigation of possible criminal activity where a participant is the victim or alleged perpetrator of a crime such as sexual abuse or assault

    Examples of law authority contacts that <u>are not</u> a critical incident include:
    - parking tickets, minor “fender-benders”, moving violations that did not pose a risk of harm to a participant

14. **Mechanical support** means an apparatus that is used to properly align a person’s body or to help a person maintain his/her balance, or to promote mobility. (Use of a gait belt to provide support during mobility activities is a mechanical support.)

15. **Medical restraint** means an apparatus or procedure that restricts the free movement of a person during a medical procedure or prior to or subsequent to such a procedure to prevent harm to the individual or aid in recovery or when used to protect an individual during the time a medical condition exists.

16. **Neglect means** an act, omission or course of conduct that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an individual.
    Examples of neglect include:
    - environmental – failure to maintain a building, furniture and associated spaces in a clean, well ventilated, and safe condition
    - environmental – failure to provide adequate sensory and mental stimulation appropriate the participant's needs
    - failure to follow plan/poor care - failure to provide support services to an individual according to the care plan or policies and procedures or in such a limited manner that the person's safety or health is compromised
    - medical - failure to provide medication as ordered, prompt and adequate physical care, seek appropriate medical treatment or report change in a participant's condition in a timely manner
    - nutritional - failure to provide adequate and appropriate food, water or other dietary services to meet the needs of the person

17. **Physical restraint** means a manual hold by a support worker or use of an apparatus other than a medical restraint or mechanical support, that interferes with the free movement of a person's limbs or body which the person is unable to remove easily.
    Examples of physical restraint include:
    - a locked room
    - a device or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily.
    - restraint by a facility staff member of a resident by use of physical force
    - disabling or interfering with a participant's use of a mobility device
    - withholding assistance to a dependent person for the purpose of interfering with the person's free movement

18. **Provider** means any person or agency that is paid by waiver, County, private or public funds for providing a service to the person.

19. **Psychotropic medication** means an antipsychotic, antidepressant, lithium carbonate or a tranquilizer.

20. **Response summary** means actions taken by the person/guardian, County or providers in response to the event or allegation.

21. **Seclusion** means physical or social separation from others by provider not including separation to prevent the spread of a communicable disease or cool down periods in an unlocked room as long as the person's presence in the room is voluntary.

22. **Service provider,** in this context, means a person who is providing paid or unpaid service or support pursuant to the person's individualized service plan. Service providers may be the person in contact with the waiver participant or someone who supervises the people in direct contact with the participant.

23. **Suicide** means the act of taking one's own life voluntarily and intentionally.

24. **Unanticipated absence** means a participant's whereabouts is unknown and he or she is considered missing.